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DAVID E. JANSSEN
Chief Administrative Officer

May 6, 2005

To: Supervisor Gloria Molina, Chair
Supervisor Yvonne B. Burke
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Officer

REPORT ON HOMELESS DISCHARGE POLICIES – STATUS REPORT

In accordance with your Board's direction on January 4, 2005, this is to provide a status report of the activities undertaken to date to review the impact of County policies and procedures regarding the discharge of at-risk and homeless persons from County institutions. Specifically, your Board directed the Chief Administrative Office, Service Integration Branch (SIB), to convene representatives from the County's heath and human service departments, Probation, Regional Planning, and the Sheriff, along with representatives of the Community Development Commission and the Los Angeles Homeless Services Authority, to discuss coordination of discharge practices among County departments/agencies and enhancement and integration of support services for the benefit of at-risk and homeless persons.

To date, SIB has convened two meetings with the above referenced departments/agencies to review and refine the data contained in the discharge planning matrix, that was included the "60-day report," with the following goals:

- Address needed modifications to strengthen existing, or create new, discharge policies and procedures;

- Ensure that optimum coordination between discharging departments/agencies and service providers occurs so that at-risk and homeless children and families are provided the support services needed to assist them to prevent or end homelessness; and

- Consider options to address the barriers that at-risk and homeless persons experience that stand in the way of their ability to secure appropriate housing and supportive services needed to sustain a healthy, productive life.

In order to achieve the above deliverables, the departments/agencies have been asked to provide SIB with a list of their unmet needs in relation to discharge policies. These departmental/agency needs are now under review. Updates to the policies continue to be incorporated into the attached draft matrix. In addition, monthly meetings of the work group continue to be convened by SIB in order to:

- Review reports and publications related to discharge policies to identify best practices that could be implemented in the County.

- Establish general discharge guidelines with common elements applicable to all departments that discharge clients; the guidelines may also include unique elements specific to the needs of a particular department.

- Review reports from newly engaged County agencies regarding their work related to homeless issues. For example, Regional Planning is working to address homeless issues by reducing regulatory barriers and has other efforts underway to increase the production of affordable housing in the unincorporated areas of the County.

- Explore the possibility of a database that would contain information on the location and availability of affordable housing.

- Consider establishing housing "locator" positions, either as County positions or by contract, to be filled with specialists who are trained in locating and maintaining a data base of affordable housing.

- Identify and define the need for new and/or enhanced rental assistance programs to assist at-risk or homeless persons in securing adequate housing.

- Work with departments named in the motion to coordinate the quarterly reports that your Board requested as follow-up to the 60-day report.

In addition to the above activities, the New Directions Task Force's Housing Alliance (Alliance), whose membership includes all departments named in the January 4 motion, is working to increase both: (1) the stock of affordable housing with supportive services for special need populations and (2) funding for rent subsidies for clients who qualify. The Discharge Work Group will work in collaboration with the Alliance and build on the success achieved by the Alliance in this area. The work of both the Housing Alliance and the Discharge Work Group are also contributing to the Prevention and Mainstream Systems Work Group of the *Bring L A Home* Blue Ribbon Panel.

We will continue to provide updates in the quarterly reports requested by your Board. The next quarterly report will be provided in July 2005.

If you have any questions or need additional information, please contact me, or your staff may contact Michael D. Castillo at (213) 974-4652 or mdcastil@cao.co.la.ca.us.

DEJ:LS
KH:MDC:os

Attachment

c: Sheriff
Director of Children and Family Services
Director and Chief Medical Officer of Health Services
Director of Mental Health
Director of Public Social Services
Director of Regional Planning
Executive Director of the Community Development Commission
Probation Officer
Chief Deputy of Community and Senior Services
Mitchell Netburn, Los Angeles Homeless Services Authority

DEPARTMENTAL DISCHARGE POLICIES AND RECOMMENDATIONS
REVISED

DEPT.	PROGRAM/ POPULATION SERVED	DESCRIPTION / BACKGROUND	STRATEGIES/RECOMMENDATIONS
DCFS		**Mission:** Will, with our community partners, provide a comprehensive child protection system of prevention, preservation, and permanency to ensure that children grow up safe, physically and emotionally healthy, educated and in permanent homes.	
DCFS	Family Preservation and Section 8 Housing Vouchers Population: Families receiving family preservation services	Since 1999, DCFS has partnered with the Housing Authority of the City of Los Angeles (HACLA), the Housing Authority of the County of Los Angeles (HACoLA), and the Santa Monica Housing Department Family Unification Program from Housing and Urban Development (HUD) to expedite the processing of Section 8 housing vouchers to families receiving Family Preservation (FP) services. Additionally, within the scope of FP, families have an opportunity to access auxiliary funding for certain limited housing purposes. ➢ **Resources:** Family Preservation Auxiliary Funds. ➢ **Purpose:** Used to pay the first month rent and/or security deposit with the intent of maintaining stability within the family. ➢ **Program Requirements/Services Provided:** Upon assessing that the family is in need of housing, the Children's Social Worker (CSW) submits a request to the DCFS FP Program Manager for approval/denial. ➢ **Capacity:** a. Total amount available Countywide: $1,302,400 b. Number of families receiving family preservation auxiliary funds: ▪ FY 2002-03, 317 families ▪ FY 2003-04, 390 families ➢ **Barriers:** a. Auxiliary funds are capped and are used to provide a full range of FP services; funding to secure housing is only one of the services. b. Decreased Section 8 funding from HUD has made collaboration with the City of Los Angeles no longer viable for DCFS. DCFS has an agreement with the HACoLA to set aside 300 Section 8 vouchers for families receiving FP services and to expedite the processing of these vouchers. Continuation of the Section 8 voucher set aside is not guaranteed given the reduction in Federal Section 8 funding.	Develop strategic partnerships/collaborations with other County departments that have resources to assist in the continued development of services to keep youth and families in safe, secure, and stable housing.
DCFS	Independent Living Program (ILP)/Emancipation Services (ES)	DCFS' ILP/ES Program, via their Emancipation Services Division, provides emancipation services to prepare and assist youth to live successfully on their own. Transitional Coordinators support children's social workers in the development of Transitional Independent Living Plans (TILP) for youth to ensure a smooth transition out of foster care and into adulthood. Preparing youth for living on their own and identifying potential homeless youth are two of the functions of the TILP.	

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	Population: Foster care youth, current and former, between the ages of 14 and 21.	➢ **Resources:** FY05-06 ILP allocation is $16,249,129; Youth Stipend allocation is $1,709,303; and, Educational and Training Vouchers allocation is $162,199. ➢ **Purpose:** To prepare youth to live independently on their own. ➢ **Program Requirements/Services Provided:** Emancipation services are delivered in a coordinated effort by transition coordinators located in each regional DCFS office and in the nine Transition Resource Centers throughout the County. Emancipation services include, but are not limited to, Early Start to Emancipation Preparation services for 14 and 15 year old youth; life skills training classes for 16 – 20 year old youth; vocational skills classes to prepare youth for trades; job skills services; college preparation and assistance; and, rental assistance for up to three months. ➢ **Capacity:** Eligible youth receive services to the extent funding is available.	
DCFS	Transitional Housing Program (THP) Population: Emancipated foster, and probation youth 18 to 21-years-of-age at risk of becoming homeless	DCFS' Transitional Housing Program is funded through 11 Federal HUD grants. Participants reside in apartments scattered throughout the County. Fair market rental rates are paid for most one- and two-bedroom apartments. A few apartments, however, are rented below market value as they are owned by the County's Community Development Commission, leased by the United Friends of the Children and rented to the THP. Rental rates for these below market units range from $330 to $750. The units are not available for permanent housing as they are used to provide ongoing transitional housing for program participants. Supportive services are provided by DCFS Case Managers. It must be noted that THP is a "program" and <u>not a housing only resource</u>. Residents *must be willing* to participate in the required program services. ➢ **Resources:** Federal HUD Grants. ➢ **Purpose:** Provide short-term transitional housing to emancipated foster and probation youth who are at risk of homelessness and provide opportunity for the youth to save enough money to move into permanent housing. ➢ **Program Requirements/Services Provided:** The program requirements include, but are not limited to, attending weekly life skills classes, school and/or working full or part-time, saving a required percentage of their earned income in an interest-bearing trust fund (which is returned to them upon completing or exiting from the program) used to secure and maintain permanent housing, and adhering to other behavioral rules of the program. Failure to adhere to the THP's requirements/rules within a reasonable amount of time results in termination, as allowing non-complying participants to remain in the program jeopardizes future grant funding. Terminated	<u>THP Terminated participants:</u> Resources other than THP must be identified / developed for homeless youth falling into this category. <u>General THP participants:</u> a. Set aside or develop affordable housing for this population and age group. Youth cannot be expected to secure and maintain permanent housing if rental expenses far out-pace their earning potential upon discharge. b. Financial and housing resources must be developed to ensure the availability of affordable permanent housing for discharged youth, if they are unable to find housing on their own. Youth under these circumstances are currently referred to shelters and are urged to consider tapping into additional resources and supports including relatives.

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		participants can appeal or file a grievance if they disagree with their termination. The Appeal and Grievance policies/procedures are mandated and approved by HUD and the Los Angeles Homeless Services Authority (LAHSA). ➢ **Capacity:** The program has a maximum capacity of 244 participants. ➢ **Barriers:** a. Many participants only want housing and are not interested in participating in other program requirements. For example, participants are unwilling or unable to maintain stable employment and generate enough savings to obtain/maintain permanent housing. b. The lack of available affordable housing, particularly for this population and age group; thus, money saved is often inadequate for permanent housing. c. THP HUD grants do not provide funding for aftercare services or housing resources. Once a youth ages out of the program, DCFS is unable to provide any financial assistance.	
DCSS		**Mission:** To assist residents in obtaining self sufficiency; strengthen and promote the independence of older persons; provide employment and training for unemployed adults, displaced workers, seniors, and young people; protect and assist adult victims of abuse; provide safety and security for domestic violence victims; and, develop services that are needed within local communities.	
DCSS	Adult Protective Services (APS) Population: Elderly and disabled persons over 21 years of age	APS contracts with 22 licensed residential care facilities County-wide to serve both elderly and dependent adults who are at risk of homelessness. These facilities are used to provide emergency housing as a last reort and time limited basis, providing the client is willing and able to accept placement and has no other immediate financial resources. APS workers also rely on clients' friends and family as potential housing resources and can issue emergency transportation vouchers. In less urgent situations, the APS social worker works with the client to assist in preventing eviction, or in locating low-income/subsidized housing. In cases where homelessness is a potential, the APS worker may make a referral for a mental health assessment and/or a referral for probate conservatorship. ➢ **Resources:** State General Funds Revenue via DPSS; DCSS' approximate annual allocation for the APS program is $25 million, of which $250,000 is used for emergency housing. ➢ **Purpose:** To investigate reports of abuse, neglect, or exploitation of elderly and dependent adults and in some cases provides emergency shelter and housing referrals for elderly and dependent adults. ➢ **Program Requirements/Services Provided:** a. The APS downtown Los Angeles Civic Center unit serves homeless elderly and disabled adults daily. If the clients are drug and alcohol free, they may be referred to a	In cases where potential homelessness exists, emergency housing arrangements does not adequately meet the housing needs of this population. What is needed is more stable, service-enriched, long-term housing options, such as those projects currently being considered/developed under the auspices of the Special Needs Housing Alliance (Alliance).

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		contractor SRO (single room occupancy) for housing. On an emergency basis, clients may be referred to Cold Weather Shelters and, if the client remains in contact, tracked so that more stabilized housing assistance can be provided. b. The majority of APS cases do not involve homelessness. However, there are a number of instances when an elderly person or dependent adult is threatened with eviction. The APS program can provide emergency housing for up to 30 days. c. In cases of imminent eviction or homelessness, APS can respond within the same day and has the capability to roll-out 24 hours per day, seven days per week. ➢ **Capacity:** In FY 2003-2004, the APS Program placed 105 elder and dependent adult clients who were temporarily homeless in safe shelter until more permanent housing could be arranged. APS projects that about 110 clients will be placed in emergency housing in FY 2005-2006. ➢ **Barriers:** Unwillingness by the client to receive services.	
DHS		**Mission:** To improve health through leadership, service, and education.	
DHS	Alcohol and Drug Program Administration (ADPA) Population: Persons with substance abuse dependency	ADPA residential service agreements require contractors to develop a basic core of residential alcohol and drug services, which include conducting an intake and comprehensive assessment of the participants' physical and emotional health; alcohol and/or drug use; and vocational/educational, legal, housing, family/interpersonal, and recreational needs. ➢ **Resources:** State General Funds (Alcohol and drug); Federal Substance Abuse, Prevention, and Treatment (SAPT) Block Grant Funds; Federal Drug/Medi-Cal funds. ➢ ➢ **Purpose:** To eliminate the homeless potential for persons being treated for drug/alcohol dependency before reaching the discharge phase of their rehabilitation program. ➢ **Program Requirements/Services Provided:** Each contractor is required to prepare a treatment plan for each participant and, if homelessness is an issue, housing is incorporated into the plan. Sixty days prior to discharge, participants are provided with multiple alternative housing resources including, but not limited to, transitional housing, satellite housing, and sober living homes. Prior to discharge, this information is reviewed and a Residential Exit Plan is prepared to assist the participant in selecting appropriate housing or, in some cases, reconciliation with family members. All residential program discharge policies require the availability of housing prior to discharge. Program participants discharged prior to their scheduled exit are sent back to the original referral source or are referred directly to other residential treatment programs. ADPA Contract Program Auditors routinely review each program's discharge policies and procedures and review client files to ensure that they contain	

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<tr><th>DEPT</th><th>PROGRAM/ POPULATION SERVED</th><th>DESCRIPTION / BACKGROUND</th><th>STRATEGIES/RECOMMENDATIONS</th></tr>
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the mandated documentation described above. Any departure from these requirements will cause the agency to develop and submit a Plan of Corrective Action to ADPA for approval to remedy the identified problem.

➢ Capacity: Approximately 2,000* beds

Summary of Residential Treatment vs. Homeless Status for FY 2003-04

<table>
<tr><th>SPA</th><th>Total Admissions</th><th>Total Homeless at Admission</th><th>Total Discharges</th><th>Total Homeless at Discharge</th></tr>
<tr><td>1</td><td>426</td><td>54</td><td>430</td><td>55</td></tr>
<tr><td>2</td><td>2,629</td><td>880</td><td>2,376</td><td>810</td></tr>
<tr><td>3</td><td>1,271</td><td>581</td><td>1,239</td><td>613</td></tr>
<tr><td>4</td><td>1,432</td><td>959</td><td>1,338</td><td>878</td></tr>
<tr><td>5</td><td>1,262</td><td>1,086</td><td>1,258</td><td>1,091</td></tr>
<tr><td>6</td><td>1,201</td><td>378</td><td>1,154</td><td>355</td></tr>
<tr><td>7</td><td>687</td><td>418</td><td>607</td><td>390</td></tr>
<tr><td>8</td><td>1,274</td><td>563</td><td>1,231</td><td>541</td></tr>
<tr><td>Total:</td><td>10,182</td><td>4,919</td><td>9,633</td><td>4,733</td></tr>
</table>
*Committed resources for existing delivery system

➢ Barriers:
Categorical funds may only be used for alcohol and drug treatment, recovery, education, and prevention services. Funding is not available for post-treatment housing.

There is a lack of permanent affordable housing.

There are insufficient residential treatment and recovery beds. The demand for services exceeds residential capacity.

There are insufficient residential and nonresidential treatment and recovery services for persons with co-occurring disorders.
</td><td></td></tr>
<tr><td>DHS</td><td>Office of AIDS Programs and Policy (OAPP)</td><td>OAPP contracts with residential facilities that provide various types of residential care for persons living with HIV/AIDS. Such care includes nursing case management, emergency or transitional housing, non-medical residential care, and substance use treatment residential services. Contractors are required to provide many</td><td></td></tr>
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	Population: Persons living with HIV or AIDS	services including, but not limited to: intake, assessment, treatment planning and discharge planning activities. ➢ **Resources:** Ryan White CARE Act and State funds. ➢ **Purpose:** To provide HIV/AIDS residential care for the following: 1) people who can no longer care for their medical needs at home, 2) people who are homeless and in need of housing, 3) people who need non-medical assistance with activities of daily living, and, 4) substance users who require residential treatment. ➢ **Program Requirements/Services Provided:** Each Contractor is required to have regular observations and assessments of resident's physical and mental condition, and to provide case management, counseling on HIV, nutrition, consultation on housing, health benefits, financial planning and other community resources. Contractors must conduct intake, assessment and treatment planning activities. The treatment plans must be updated every 3 months. Contractors are required to conduct the following discharge planning activities: linkages to medical, emergency assistance, supportive and early intervention services, services that promote access to support services such as case management, meals, nutritional support and transportation. In addition, Contractors must provide linkage to housing opportunities including, but not limited to permanent, independent, supportive and long-term. ➢ **Barriers:** Lack of permanent housing resources.	
DHS	Hospitals, Comprehensive Health Centers Population: Hospital patients and persons who visit clinics on an outpatient basis	DHS provides discharge planning at all of its inpatient and outpatient facilities. Facilities have varying policies/strategies for how discharge planning is conducted, however the methodologies are similar. ➢ **Resources:** N/A ➢ **Purpose:** To ensure that patients are discharged to a safe and appropriate environment. ➢ **Program Requirements/Services Provided:** There are several points during inpatient or outpatient visits that patients with psychosocial needs including homelessness are identified: upon admission, when seen by a healthcare provider, and throughout the stay. Referrals are made to the Social Work, Utilization Review or Discharge Planning Departments, depending on the staffing/departmental structure of the facility. Discharge planning begins once the assessment of needs has been made by the appropriate department. Inpatient facilities have stringent policies to ensure that patients are discharged to a safe and appropriate environment. Homeless patients are usually discharged to emergency shelters, unless they have medical needs requiring a higher level of care.	

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		➢ **Capacity:** All inpatient and outpatient clients are screened for discharge planning needs so that they are discharged to an appropriate environment. The "capacity" issue really relates to finding appropriate environments for discharged patients to move into. ➢ **Barriers:** a. Sometimes homeless individuals refuse referrals/placement; b. Not enough resources/affordable housing options are available to provide an appropriate discharge plan (shelters are not always appropriate); c. Data collection systems do not include elements about housing stability or lack thereof; d. No standardized discharge protocol exists for DHS facilities; e. No follow-up on referrals to ensure linkage; f. Healthcare providers emphasize discharge planning to varying degrees; g. Substance abusers are not accepted at many facilities, including homeless agencies; h. Difficult to follow-up with homeless persons to engage them in healthcare; i. Limited resources for undocumented individuals; and j. Many stages during inpatient stays cause discharge planning to be delayed.	
DMH		**Mission:** To enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access treatment and support services. (This is the mission of the California health system, which has been adopted by the County DMH.)	
DMH	Child, Youth and Family Program Administration Countywide Case Management Unit Children's Inpatient Clinical Case Management (CICCM) Unit Population: Foster and probation children and youth who may have mental health issues and are enrolled in Medi-Cal	The CICCM Unit was developed in 1995 with the implementation of Phase I of Medi-Cal consolidation to improve linkage and integration of services between the psychiatric hospitals and the community outpatient system of care. ➢ **Resources:** EPSDT Medi-Cal ➢ **Purpose:** To provide input on the mental health issues of the population. The DMH case manager's review of admissions, treatment, and discharge plans for all Medi-Cal clients in the hospital. Case managers participate in treatment conferences, DCFS/RUM (Resource Utilization Management) conferences, and consult with the hospital discharge planners and clinical staff. In addition, charts, Information System (IS) printouts and aftercare plans are reviewed. ➢ **Program Requirements/Services Provided:** a. **Collaboration and Mental Health Assessment and Link to Services**: DMH case managers focus intensive services on children living at home that have not been linked to ongoing outpatient mental health services following one or more hospitalization; participate in interagency DCFS planning conferences for foster children with multiple placements and hospitalizations; and collaborate with and consult with Probation	Augmenting CICCM staffing resources will provide more intensive and timely consultation services. Increased resource development should be a primary feature of any plan to address potential for homelessness with this population, i.e., including access to in-home mental health services, respite care, increased benefits establishment, and specialized residential placements.

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		representatives regarding hospitalized wards of the Juvenile Court who have been hospitalized multiple times. b. **Coordination with local system of care:** Participation in local mental health planning meetings is another function of the DMH case manager as it is a way to share information and procedures, identify gaps in services and collaborate with other service providers. The DMH case workers have a collaborative working relationship with DCFS regional offices, including participation in MARPRT (Multi Agency Regional Placement Resource Team); AB 3632 services; System of Care/Wraparound; transitional youth services; and community mental health providers, improves service access and integration for clients. The case manager serves as a link for the client between inpatient and outpatient services. c. **Discharge Planning:** A major role of the DMH case manager is to ensure that appropriate mental health services are provided upon discharge. Case information and the client's aftercare forms are reviewed, and specific Countywide data is collected to track linkage and ensure clients are referred for ongoing treatment. Cases requiring more intensive follow-up are opened on TS so that children and their families can receive additional support, assistance, and follow-up to access services they need following hospitalization. d. **Procedures for Discharge:** CICCM staff participates in interagency discharge planning meetings for children at risk of homelessness. They provide consultation for mental health services and placement options. CICCM staff follows the client into the community to ensure that linkage with appropriate mental health services is established. ➢ **Capacity:** 200 per year ➢ **Barriers:** Client discharges are impacted by a lack of available resources in the community, i.e., outpatient mental health clinics, residential placements, lack of funding, lack of specialized services for children with serious medical conditions, and lack of family support/respite care.	
DMH	AB 2034: Comprehensive services to mentally ill persons Population: Homeless mentally ill persons 18 years and older not connected to services and institutionalized in jail	AB 2034 is a State financed program to do "whatever it takes" to provide comprehensive, integrated services to meet individuals' needs, which includes housing and employment. This program is designed as a paradigm shift in the delivery of services to homeless, mentally ill individuals. ➢ **Resources:** State AB 2034 Funds and County General Funds ➢ **Purpose:** a) To assist mentally ill clients that are homeless, not currently connected to services (many of whom are incarcerated or have a history of incarceration), to improve their quality of life. b) To prevent mentally ill persons being discharged from institutions to homelessness. c) To provide mentally ill inmates and patients with: residential stability; decreased hospitalizations and incarcerations; increased level of functioning; and increased independence, including	➢ Increase AB 2034 funding and increase the number of AB 2034 recognized agencies. ➢ Develop better protocols to ensure releasing institutions notify DMH's AB 2034 staff.

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	or mental health facility	employment. ➢ **Program Requirements/Services Provided:** a. **Jail Linkage:** Since the creation of AB 2034, DMH has provided an outreach component located in the Twin Towers Correctional Facility Center. The AB 2034 Program staff located in the jail focuses on outreaching to inmates housed in the mental health sections of the jail who have been identified as being homeless at the time of their arrest and those who will be homeless at the time of their release. The AB 2034 Program staff interviews those inmates to determine if they meet the program's criteria for eligibility and, if eligible, the inmate is referred to one of the 15 AB 2034 agencies in the County. The AB 2034 agency will interview the inmate to ensure program compatibility and begin discharge planning which includes arranging for pick-up at the time of release. The AB 2034 agency will provide immediate and/or transitional housing upon the inmate's release. b. **Other Linkages:** AB 2034 also provides linkage to housing for patients of residential treatment facilities and hospitals. c. **Transportation:** AB 2034 agencies arrange for pick-up when AB 2034 eligible persons are discharged from residential treatment facilities, hospitals, and jails in order to ensure that they transition without incident. d. **Housing:** AB 2034 providers, utilizing flexible funding established in the original legislation, are able to provide emergency, immediate, and transitional housing for participants who would otherwise remain on the streets or in overnight shelters. The funds are used to master lease property that can be used to house participants in lieu of them remaining on the streets. In addition, the funds are used to pay for motel and hotel vouchers. Once participants are placed in temporary housing situations, the AB 2034 providers assist them in securing permanent housing. The flexible funding allows AB 2034 providers to assist participants with move-in expenses, furniture, and other housing related costs. ➢ **Capacity:** 1700 clients per year ➢ **Barriers:** a. There is a greater need for AB 2034 agencies and services than there is available funding. b. Early Release: Although DMH coordinates with the County jails and other inpatient institutions, sometimes clients are released without notification to DMH AB 2034 staff.	
DMH	County Hospital Adult Linkages Program	ALP's mission is to assist with the coordination of psychiatric services for DMH clients at DHS Hospitals through a DMH County Hospital Liaison assigned to each County hospital.	There is an identified need for increased residential housing options that includes intensive mental health services; adequate

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	(ALP) County Hospital Liaison Population: Patients of County Hospitals	➢ **Resources**: Funding from County General Funds, Supplemental Security Income (SSI). Four liaisons for the inpatient units and four liaisons for the psychiatric emergency services after April 1, 2005. 2.5 peer advocates are planned for FY 05-06. ➢ **Purpose**: To ensure that clients being discharged are linked with the appropriate level and type of mental health, residential, substance abuse, or other specialized programs. ALP promotes the expectation that clients must be successfully reintegrated into their communities upon discharge and that all care providers must participate in client transitions. ➢ **Program Requirements/ Services Provided:** In collaboration with the DHS Hospital Liaison and DMH program management, the DMH County Hospital Liaison: a. Collaborates with the DHS treatment teams to assist in developing aftercare plans for clients identified with intensive and complicated service needs. This may include facilitating the submission of required documentation for referrals to long-term residential placements. b. Provides consultation to hospital staff and discharge planners regarding community alternatives available to clients on inpatient units and psychiatric emergency rooms. c. Identifies Intensive Service Recipients (ISR) by Services Areas (SA) and refers them to DMH's SA Impact Teams for linkage to outpatient providers. d. Collaborates with community providers to facilitate linkages to community-based resources. Liaisons attend Impact Team meetings in the designated County Hospital SA and participate in SA Advisory Committee (SAAC) meetings. e. Identifies system barriers, including social and financial barriers, to successful reintegration of clients into their communities and works with DHS staff and identified agencies and providers to resolve these barriers. f. Participates in the management and allocation of treatment resources among high need populations. g. Participates in the collection of DMH outcome data related to discharges from County Hospitals. ➢ **Capacity**: Varies. Liaisons are involved with treatment teams in all County hospitals to facilitate linkage to community placements on a daily basis. This averages about 35 per week or 1820 per year. Additional staff in psychiatric emergency services will double capacity to 3640. ➢ **Barriers:** Barriers include a lack of access to outpatient mental health and medical services for uninsured clients, lack of enhanced residential placements with specialized programs for individuals recovering from substance abuse, adequate levels of interim funding for uninsured clients, and legal issues.	levels of interim funding; programs in County Hospitals to identify and establish benefits for patients being discharged; and access to outpatient, community-based medical and substance abuse treatment services.

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DMH	Adult Hospital Linkage (AHL) Project Population: Adults and Older Adults with serious mental illness	The AHL Project enhances the "system of care" for individuals that utilize acute mental health hospital services by bringing together diverse stakeholders that play critical roles in the lives of adults and older adults. Implementation of the AHL Project is currently focusing on the needs of ISRs – individuals who have a serious mental illness and have had six or more psychiatric hospitalizations within a consecutive 12-month period. ➢ **Purpose:** a. To ensure rapid access and linkage to the appropriate level of care for individuals being discharged from inpatient facilities; b. Prevent further hospitalization when appropriate; and c. Implement new strategies for collaboration between inpatient and community-based services, designed to ensure continuity of care. ➢ **Resources:** County General Funds, some Medi-Cal ➢ **Program Requirements/ Services Provided:** a. Service Area Impact Units (SAIU) are composed of representatives of programs providing services to ISRs, including outpatient mental health programs (Assertive Community Treatment (ACT), AB 2034) which provides outreach and integrated community-based services to individuals who are homeless and have a mental illness including those who are involved with the criminal justice system, Adult Targeted Case Management Services (ATCMS), and general outpatient programs), Emergency Outreach Bureau, local hospitals, and housing coordinators. As needed, SAIUs also involve representatives of other programs, such as the Regional Center and local residential facilities. b. A key member of the SAIU team is the Hospital Liaison – a DMH staff person who regularly visits local inpatient programs, identifies ISRs, and links them with intensive services. As they identify ISRs hospitalized locally who reside in another part of the County, Hospital Liaisons contact one another in a timely fashion, thereby ensuring successful coordination of care across SA boundaries. c. Presently, SAIUs are beginning to develop crisis management plans with clients and family members that may assist mobile response teams or hospitals in preventing hospitalization or reducing the disruption caused when an admission becomes necessary. ➢ **Capacity:** Varies over the course of the year, approximately 300 clients were served through	Stable housing, including specialized residential placements, adequate levels of interim funding, and the expansion of community-based mental health and substance abuse services are needed to assist clients with a serious mental illness who are at risk for homelessness.

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		this project. ➢ **Barriers:** Lack of stable housing and residential care placement alternatives constitute major obstacles to successful community placement of ISRs. A lack of residential alternatives include specialized residential programs for individuals with mental illness who are in recovery, augmented residential treatment placements for individuals who require more intensive mental health services, short-term crisis residential programs, and adequate levels of interim funding for uninsured individuals. There is an ongoing need for more availability of Assertive Community Treatment (ACT) programs in some geographic areas.	
DMH	Institutions for Mental Diseases (IMD) – State Hospital Transition Project Population: Mentally ill patients of State Hospitals	In July 2004, DMH implemented the Institutions for Mental Diseases (IMD)-State Hospital Transition Project to transition clients from long-term residential settings to community placement with ACT programs. Important components of the project include enhanced IMDs, ACT programs, residential services, and peer support programs. The project has several phases: assessment, placement/linkage, and follow-up. ➢ **Resources:** Supplemental Social Security Income (SSI) and County General Funds. ➢ **Purpose:** To transition approximately 180 DMH clients safely and successfully from State Hospitals and IMDs to lower levels of care, including independent living, with intensive mental health services. ➢ **Program Requirements/Services Provided (Discharge Planning Procedures):** a. IMD Administration staff identified and referred 80 clients in State Hospitals and 267 clients in IMDs with the potential for discharge readiness and determined the level of care required on discharge from June 17, 2004 to the present. b. Based on assessments, clients were referred to enhanced IMDs from the State Hospitals or community placements with ACT programs. c. Clients determined to be ready for discharge from IMDs were referred to ACT programs for community placement. ACT team members met with IMD staff, clients, and conservators to develop discharge plans that included residential placement and mental health services based on the needs of individual clients. d. Interim funding for residential placements was made available by the IMD Administration for IMD clients who were without funding resources. e. Peer support services were an important component of the plan and were incorporated into each IMD program. Peer "bridgers" assisted in preparing clients while they were in the IMD for the community, and provided support and linkage to community peer resources after discharge. f. Outcome measures were established to monitor the progress of the project including: e rates of re-hospitalization, adverse incidents, readmission to IMDs, incarcerations, and AWOLS (away without leave).	The transition project identified the need for the development of augmented residential placements with intensive mental health services, including specialized programs, stable housing resources, more ACT and AB 2034 programs, and adequate levels of interim funding to assist in transitioning clients safely and successfully to the community.

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		➢ **Capacity**: Since July 1, 2004, 180 mental health clients were successfully transitioned from State hospitals and IMDs to lower levels of care. ➢ **Barriers:** a. Increased levels of acuity. b. Lack of available residential beds, including specialized programs for transitional age youth, older adults, forensic, substance abuse, etc. c. Lack of availability of ACT, ACT-like, and AB 2034 programs in some SAs.	
DMH	Section 8 Shelter Plus Care (S+C) Program Population: Homeless mentally ill clients of County DMH	DMH receives Section 8 S+C Program grants from both HACLA and HACoLA. The program provides eligible homeless DMH clients with a five-year rental subsidy certificate and mental health services to help maintain living independently in the community. ➢ **Resources:** Federal HUD Section 8 Housing assistance vouchers from the City of Los Angeles and the County of Los Angeles. ➢ **Purpose:** To provide clients with access to affordable permanent housing and ongoing mental health services to maintain living independently in a community setting. ➢ **Program Requirements/Services Provided:** a. Rental subsidization certificates for a five-year period (renewable) along with mental health services. b. Clients must meet the HUD definition of homelessness, be capable of living independently in the community, be connected to a DMH outpatient clinic or contract agency with a designated case manager, and agree to continue receiving mental health services. c. Process for applying and receiving funds: Case managers complete applications on behalf of their eligible clients and the applications are forwarded to the appropriate Housing Authority. Certificates are issued within four to six weeks. Clients have six months in which to find housing. ➢ **Capacity:** Varies per fiscal year. In 2004, DMH was awarded 85 certificates from the HACoLA and 50 certificates from the HACLA. Approximately 265 clients are currently enrolled in the S+C Program through DMH. Community-based agencies working with the homeless mentally ill also receive separate grants from these and other city housing authorities. ➢ **Barriers:** a. There are a limited number of certificates available for homeless mentally ill clients seeking affordable permanent housing. b. There are not enough affordable housing units available to meet the housing demand.	➢ Advocate for more Federal funds to support rent subsidization for special needs populations. ➢ Advocate for more Federal/State funds to increase the inventory of affordable housing and, in particular, to provide funding for the necessary supportive services that are critical to accompany such housing.

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		c. The Homeless Section 8 program has been discontinued for the time being by the Federal government, thus limiting the number of rental subsidies available for special needs populations.	
DMH	Rental Assistance Program Population: Homeless mentally ill persons	DMH sets aside funding from its Projects for Assistance in Transition from Homelessness (PATH) grant and other resources to provide first month and security deposit funds to eligible homeless clients moving into a affordable housing or for clients facing eviction. The definition of homelessness depends on the source of the funding, but may include clients moving out of hospitals and board and care facilities into independent living in the community. ➢ **Resources:** Funding comes from DMH's PATH grant, Substance Abuse and Mental Health Services Administration funds and the Emergency Housing Assistance Program. These are Federal HUD funds. ➢ **Purpose:** To provide access to affordable permanent housing by covering the initial costs associated with moving into a new rental unit specifically financial assistance with first month rent, security deposit and move-in costs. ➢ **Program Requirements/Services Provided:** a. Clients must be homeless, as defined by the funding source, and meet the financial/homelessness eligibility criteria established by HUD, be capable of living independently in the community, be connected to a DMH outpatient clinic or contract agency with a designated case manager, and agree to continue receiving mental health services. b. Process for applying and receiving funds: DMH outpatient case managers complete applications on behalf of their clients. ➢ **Capacity:** Total amount available varies each fiscal year. In FY 04-05, DMH spent $123,000 and served a total of 87 clients. ➢ **Barriers:** There are not enough funds to accommodate the needs of homeless clients who have identified affordable housing but lack the resources to cover the move-in costs. The majority of funding is Federal and requires clients to meet the strict federal definition of homelessness that does not include clients transitioning out of hospitals, board and care facilities and other institutions.	➢ Advocate for more funds to cover move-in costs for homeless clients who have identified permanent affordable housing and do not have the resources to provide the up-front costs required by all landlords. ➢ Advocate for a more liberal definition of "homelessness."
DMH	Specialized Shelter Bed Program Population: Homeless mentally ill persons who are DMH outpatient	DMH has contracts with shelters that set aside beds for DMH client referrals who are homeless and have no source of funds. Clients can remain in the shelter for a maximum of six months. **Resources:** The program has an annual encumbrance of $825,000 of County General Funds. ➢ **Purpose:** To provide temporary shelter and food to DMH homeless indigent clients until they have their benefits established or secure an income and move into affordable permanent housing.	Advocate for more funds to provide shelter for DMH outpatient mentally ill clients.

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	clients	➢ **Program Requirements/Services Provided:** a. Clients must be homeless, indigent, and associated with a DMH outpatient clinic and have a designated case manager. Clients can stay in the shelter for up to a maximum of six months. b. Process for applying and receiving funds: DMH outpatient case managers contact the respective DMH gatekeeper for each shelter. The gatekeeper approves the enrollment depending upon the shelter's current capacity and must also approve each 30-day extension up to the six month maximum. ➢ **Capacity:** In FY 03-04, DMH contracted with 15 Shelters a capacity to provide basic living services to approximately 80 clients each month. ➢ **Barriers:** There are not enough funds to accommodate the needs of homeless DMH clients, particularly families with young children.	
DMH	Mental Health Court Program (MHCP) Community Reintegration Program Population: Mentally ill persons involved in the criminal justice system	DMH through the Mental Health Court Program's Community Reintegration Programs offers mentally ill defendants community-based treatment as an alternative to incarceration. The program contracts with two mental health facilities to provide comprehensive services to mentally ill persons exiting the legal system. ➢ **Resources:** County General Funds ➢ **Purpose:** a)To provide mentally ill defendants treatment as an alternative to incarceration b) to reintegrate consumers into the community with the skills and resources necessary to maintain stability c) to reduce recidivism ➢ **Program Requirements/Services Provided:** a) **Collaboration with criminal justice system:** MHCP staff work with defense attorneys to refer appropriate candidates and to obtain Community Reintegration as part of the disposition of the criminal case. b) **Coordination with Sheriffs Department:** MHCP staff facilitate with jail staff the release and transportation of consumers from jail to contract facilities. c) **Consultation with Providers:** MHCP staff liaison with treatment team and provide input on discharge planning. Discharge plans are based on the needs of the consumer d) **Benefits Establishment:** Benefits are suspended during incarceration. Specially designated facility staff restore benefits or assist consumers with new applications ➢ **Capacity:** 70 beds ➢ **Barriers:** a) lack of housing resources for consumers who not eligible for benefits b) lack of affordable housing c) long delays for community based treatment d) stigma in the community	Advocate for Increase housing options and for improved access to community-based services.

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		related to population d) lack of specialized housing options with intensive mental health services.	
DPSS		**Mission:** To provide effective services to individuals and families in need, which both alleviate hardship and promote personal responsibility and economic independence. To focus on positive outcomes, quality, innovation and leadership. We believe that to fulfill our mission, services must be provided in an environment which supports our staff's professional development and promotes shared leadership, teamwork and individual responsibility.	
DPSS	CalWORKs – Current clients Population: Families and persons eligible for CalWORKs	To assist families exiting a domestic violence situation, eviction, shelter, or general homelessness, DPSS offers the following homelessness prevention services to families as they enter DPSS: **RENTAL ASSISTANCE TO PREVENT EVICTION** ➢ **Resources:** CalWORKs Single Allocation funds and Performance Incentive-Net County Cost (PI-NCC) dollars ➢ **Purpose:** Prevent families from losing their permanent housing. ➢ **Program Requirements/Services Provided:** Persons receiving funds must be eligible for CalWORKs. ➢ **Capacity:** DPSS approves about 250 housing vouchers per month for a total of nearly $160,000. The voucher amount depends on family size, and therefore, the number of families served varies. ➢ **Barrier:** DPSS uses its Single Allocation "services" and PI-NCC dollars to provide this cash assistance. These are not entitlements. Therefore, the program is only available on a year-to-year basis depending on the availability of funding. **TEMPORARY HOMELESS ASSISTANCE** ➢ **Resources:** CalWORKs Single Allocation funds and PI-NCC dollars. ➢ **Purpose:** Augments the State's Homeless Assistance Program by providing County Single Allocation funds to extend the time homeless CalWORKs eligible families can stay in hotels/motels for up to 30 days. ➢ **Program Requirements/Services Provided:** a. The State's temporary Homeless Assistance program is limited to 16 days. Additional Single Allocation funding was available in FY 2004-05, and DPSS dedicated $1.5 million	**Recommendations for CalWORKs Participants:** 1. Expand linkages with other departments and agencies (DCFS, Probation, Sheriff, Courts, Public Defender, DHS, schools, and EDD) to connect families exiting these systems to connect with DPSS services. 2. Provide "life skills" and "money management" classes to families and individuals to better prepare them for exiting DPSS. 3. Intervene with families that include a child age 18. ➢ Work with/prepare 18 year olds to transition them to employment. ➢ For families facing discontinuance once the only eligible child turns 18, connect the parent with services that will most quickly lead to employment.

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		to supplement the State's program with an additional 14 days, to provide a total of 30 days. DPSS uses its Single Allocation "services" and PI-NCC dollars to provide the additional 14 days, but this is not an entitlement. b. Without the 14-day supplementation, families would be limited to only 16 days of shelter. With the limited continuum of care in the County (i.e., shortage of affordable housing, transitional housing, and emergency housing, etc.), this 16-day limitation restricts the ability of families to find permanent housing. ➢ **Capacity:** DPSS approves over 1,000 hotel/motel vouchers per month for a total monthly amount of nearly $500,000. ➢ **Barriers:** a. The County supplementation is only available on a year-to-year basis depending on the availability of funding. b. The State limits temporary Homeless Assistance to $40 per night for a family of four. In Los Angeles County, the average motel stay is nearly always more than $40, often resulting in families receiving reduced days of shelter. For example, if a family is issued $280 for seven nights' shelter and they have to pay $60 per night, they can only afford four days of shelter instead of seven. **ADDITIONAL INTAKE SERVICES** ➢ **Resources**: CalWORKs Single Allocation funds and PI-NCC dollars. ➢ **Purpose:** To expedite/process CalWORKs applications for homeless families. ➢ **Program Requirements/Services Provided:** a. Outreach to missions/shelters to process CalWORKs applications. b. Outstation eligibility staff at the Weingart Access Center in Skid Row to process CalWORKs applications and requests for housing assistance. c. Supplement LAHSA's emergency shelter system with funding to purchase additional shelter/vouchers, allowing CalWORKs families to have shelter (up to 120 days) while they seek permanent housing. d. Establish a Skid Row outreach team, made up of LAHSA, DMH, and DCFS staff to identify homeless families and link them with services. ➢ **Capacity:** In FY 2004-05, DPSS used approximately $1.7 million of its Single Allocation "services" dollars to fund outreach staff and supplement the County's emergency shelter/voucher system. ➢ **Barriers:** This is not an entitlement program. The ability to provide supplementation funding is	

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		only available on a year-to-year basis depending on funding availability. **RENTAL SUBSIDY** ➢ **Resources:** CalWORKs Single Allocation funds and PI-NCC dollars. ➢ **Purpose:** Subsidizes rent payments to assist (recently homeless) CalWORKs families who have located permanent housing. ➢ **Program Requirements/Services Provided:** Effective January 2005, DPSS began issuing up to $250 per month, for up to four months, to help families afford their rent payments. There is not yet any issuance data on this program. ➢ **Capacity:** Unknown at this time. ➢ **Barriers:** DPSS uses its Single Allocation "services" and PI-NCC dollars to provide this cash assistance - these are not entitlements. Therefore, the program is only available on a year-to-year basis depending on funding availability. **PERMANENT HOMELESS ASSISTANCE AND MOVING ASSISTANCE** ➢ **Resources:** CalWORKs Single Allocation funds and PI-NCC dollars. ➢ **Purpose:** Pays for security deposits, first and last month rent, etc., allowing families to move into permanent housing. ➢ **Program Requirements/Services Provided:** CalWORKs eligible families receive funding to assist them in securing permanent housing. ➢ **Capacity:** DPSS issues about 500 of these payments monthly for a total monthly cost of nearly $550,000. ➢ **Barriers:** a. The State's Homeless Assistance program (both temporary and permanent) are once-in-a-lifetime programs - meaning a client can receive only once, with the following exceptions, when homelessness is the result of: 1) a natural disaster; 2) uninhabitability of a dwelling caused by unusual circumstances beyond the family's control, such as a fire; 3) a medically-verified medical/mental illness, excluding alcoholism, drug addiction or psychological stress; or 4) domestic violence. As homelessness tends to be episodic, this limitation restricts the assistance that DPSS can provide in repeated incidents of homelessness. b. DPSS uses its Single Allocation "services" and PI-NCC dollars to provide the Moving	

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		Assistance program. This is not an entitlement; therefore the program is only available on a year-to-year basis depending on funding availability. **CLIENTS EXITING CalWORKs** ➢ **Resources:** CalWORKs Single Allocation funds ➢ **Purpose:** Assisting adults and families exiting CalWORKs due to time limits, employment, or who are at risk of being sanctioned for another purpose to prevent them from becoming homeless. ➢ **Program Requirements/Services Provided:** 1. **Adults** a. Meet with adults scheduled to exit CalWORKs to ensure they are aware of the services available to them which may assist in reducing the risk of homelessness. b. Offer post-employment and post-time limited services, including case management, transportation, child care, ancillary/work-related benefits, and homelessness prevention services (such as moving assistance and rent to prevent eviction). c. Conduct home calls in one pilot region to adults facing sanction in an effort to address barriers and reengage them in GAIN, reducing the risk of homelessness. 2. **Families:** For families exiting CalWORKs due to total case terminations: a. Continued medical coverage for the family. b. Continued food stamp benefits for five months. ➢ **Capacity:** These services are available to all CalWORKs adults, about 600 monthly, who are exhausting their 60 month time limit. ➢ **Barriers:** DPSS uses its Single Allocation "services" and PI-NCC dollars to support the Moving Assistance program. This is not an entitlement, therefore the program is available on a year-to-year basis depending on funding availability.	
DPSS	General Relief (GR)/ Food Stamps (FS)/ Cash Assistance Program for Immigrants (CAPI) Population: Refugee who are discontinued from SSI/SSP	DPSS connects eligible refugees whose SSI/SSP benefits have been discontinued with GR/FS/CAPI services. ➢ **Resources:** County General funds and Federal funds ➢ **Purpose:** Outreach to potentially eligible refugees discontinued from SSI/SSP to connect them with CAPI. ➢ **Program Requirements/Services Provided:** Cash assistance is provided by the County to refugees that have had their SSI/SSP benefits discontinued.	

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		➢ Cash aid to GR applicants to prevent eviction or utility-shutoff. The maximum amount of aid issued for both eviction and utility shut-off is $136. ➢ For GR applicants who find a job prior to approval, cash aid is available pending their first paycheck. ➢ Food and housing vouchers while GR is pending. ➢ Outreach at Twin Towers to process/expedite GR applications of inmates with mental health issues who are scheduled for release. ➢ SSI advocacy with continued GR payments pending receipt of SSI/SSP. ➢ Welfare-to-work services through the General Relief for Opportunities for Work (GROW), which strives to transition GR participants into the labor market, thus providing an ongoing opportunity to avoid homelessness. ➢ Case management, during which GROW case managers discuss issues affecting participants, including homelessness, and making referrals to available services. ➢ Food Stamp outreach efforts evaluate families' other needs for services, connecting them with other DPSS services, including cash aid/homelessness prevention services to stabilize housing. ➢ **Capacity:** Per SSA, the projected number of refugees in this category is: 1,600 Statewide; of which, 526 are located in the L.A. Metro Region. ➢ **Barriers:** The effectiveness of this outreach is dependent on the Social Security Administration providing a data file of persons living in the County who are scheduled to term off SSI due to the seven year time limit. Pending the data file, a centralized mailing outreach campaign is not possible - only fliers are possible, restricting outreach.	
DPSS	Medi-Cal Medi-Cal Eligible Persons	DPSS outstations staff in private hospitals to take and process Medi-Cal applications from both inpatients and outpatients. The applicants' subsequent approval of benefits contributes to their financial security, thereby reducing the risk of homelessness.	
DPSS	In-Home Supportive Services (IHSS) Population: Elderly and Disabled Persons	IHSS works closely with: ➢ Hospitals to determine eligibility and assess service needs of patients that will be discharged to home and to ensure service provider availability. ➢ Adult Protective Services to locate shelter and to plan for long-term housing for recipients in danger of eviction from their home.	
Probation		**Mission:** To promote and enhance public safety, ensure victims' rights, and facilitate the positive behavior change of adult and juvenile probationers.	
Probation	Discharge Planning	When suitable placement is recommended, the Foster Care Case Plan (Probation 1385) and the Transitional	Support the development of service-enriched permanent

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	for Probation Foster Youth Population: Foster care youth, current and former, between the ages of 14 and 21, in the Probation system.	Independent Living Plan (TILP) must be completed prior to disposition. When a youth is ordered suitable placement, and suitable placement was not recommended, the Probation Officer has 30 days to complete the Foster Care Case Plan (Probation 1385) and the TILP. These, along with Probation's Judicial Review Court Report, are the documents used to prepare our foster youth for discharge. The goal of each plan is to reunify the youth with their respective families (when it is viable, safe, and in the best interest of the youth). A concurrent plan for all foster youth is required because many foster youth do not have a tenable family support system. In each case plan, the concurrent plan focuses on permanent alternatives to living with their families. These plans may include long-term foster care, legal guardianship and/or adoption. Emancipation can be a service component if long-term foster care is the permanent goal. Preparing youth for living on their own and identifying potential homeless youth are two of the functions of the TILP. This document is prepared as soon as the youth enters foster care or reaches age 14. The TILP is the second half to our foster case plan and accompanies each Judicial Review Court Report, giving the Court information on the youth's permanent plan and preparedness for emancipation. When housing is identified as a need, the TILP is updated to reflect this and the youth is referred to the Transitional Housing Program (THP) prior to their 18th birthday. The Probation Officer of record will follow the established policy on how and when to refer the youth. Each case is screened and referred to the appropriate providers. When the youth is accepted to a program, the Probation Officer notifies the Court and asks that jurisdiction be terminated. After the Court terminates probation, the youth is transported to the housing program. The department's housing intake coordinator then tracks their entry date and the THP program that the youth entered. The youth remains eligible for services until their 21st birthday. **Target Population:** Youth that are removed from their homes, are under the supervision of the Probation Department, are suitably placed and considered foster youth. 1. **EMANCIPATION PROGRAM** (formerly known as Independent Living Program for foster youth; Coordinating Memorandum No. 2003-22) ➢ **Resources:** Chafee ILP Funding, Title IV-E Funding, and HUD Grant Funding ➢ **Purpose:** Preparation for emancipation and post-discharge sustainability in the community for current and former foster youth. ➢ **Capacity:** N/A ➢ **Barriers:** a. Limited housing resources for ILP eligible youth (850 beds for the entire County). b. Severely limited housing for non-ILP eligible youth (40 beds).	housing for emancipated foster youth with families, such as the Mason Court Apartments Project (described briefly below) currently being developed under the auspices of the Alliance. Mason Court Apartments Project ➢ **Purpose:** To preserve the family unit (emancipated youth with children) by providing safe and stable, multi-department services-enriched housing. ➢ **Services include:** DCFS FP and emancipation services, room and board, tuition assistance, driving lessons, car insurance etc. ➢ **Barrier:** Limited to Wards of the Dependency Court.

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		c. Non-existent supportive transitional housing for chronically mentally ill youth 2. **TRANSITIONAL INDEPENDENT LIVING PLAN (TILP)** (Coordinating Memorandum No. 2003-23) ➢ **Resources:** Title IV-E and Chafee Funding ➢ **Purpose:** Plan for discharge of foster youth and provide housing/services as they emancipate ➢ **Capacity:** All foster youth ages 14 and above. ➢ **Barriers:** Applies only to foster youth (which represents 10-15 percent of Probation juvenile population). Excludes non-ILP eligible youth with housing needs. 3. **TRANSITIONAL HOUSING REFERRAL PROCESS** (Coordinating Memorandum No. 2003-04) ➢ **Resources:** Title IV-E, Chafee Funding, EDPST Funding, HUD Grant Funding, and AB427 Funding ➢ **Purpose:** Puts into effect the TILP when housing has been recommended. Provides safe and stable housing for youth after foster care. ➢ **Capacity:** 852 beds available ➢ **Barrier:** Only applicable to foster youth and does not address the chronically mentally ill population **See also:** Department of Children and Family Services - Transitional Housing Program.	
Probation	Discharge Planning for Residential Treatment and Services Bureau (RTSB) (Camp) Youth who are on probation and living at a juvenile camp	When a youth is under the supervision of the Probation Department and housed at a Probation Camp, the Residential Treatment and Services Bureau is responsible for determining where the youth will live upon discharge. ➢ **Resources:** County General Funds and Temporary Aid to Needy Families Funding ➢ **Purpose:** To ensure that youth discharged from Probation camps are housed in a safe, stable situation that is authorized by the Court.	

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		➢ **Program Requirements/Services Provided:** The first choice is reunifying the youth with their families. A home assessment by a field Deputy Probation Officer is conducted prior to the youth's release. If the home is found to be suitable, the parents sign a reunification contract that includes a parental sign-off and agreement to follow the Case Plan. If the field Probation Officer finds the home to be untenable or if the family structure has changed and the youth cannot reunite with his/her family, a Change of Plan Court Report is submitted to the Court to identify the youth's need for long-term foster care or emancipation services. The youth is then sent back to Court and ordered suitable placement until the youth can enter emancipation housing or find an alternative permanent plan. The aforementioned policies will then be followed. In 2004, 4,691 Camp Youth were returned to the community. ➢ **Capacity:** Board of Corrections (B.O.C.) rated capacity of 1982 minors. ➢ **Barriers:** 1. The parent, guardian, or relative is unwilling to take the minor back upon release for various reasons (e.g., minor is considered uncontrollable, etc.). 2. The home situation is determined to be unsuitable for minor upon release due to various issues (e.g., gang activity, drug use, alcoholism, etc.).	
Probation	Adult Probation Services Adults sentenced to probation by the Court	The Probation Department is responsible for assisting adult probationers in reestablishing and promoting healthy, productive lifestyle. ➢ **Resources:** 131 DPO II positions at $91,000 per year for a total of $11,921, 000. ➢ **Purpose:** To identify the needs of the adult probationer and their family through a strength-based needs assessment in order to promote and reestablish healthy and productive lifestyles ➢ **Program Requirements/Services Provided:** The emphasis of the Adult Services Bureau is not so much with discharge planning, but with identifying the needs (employment, education, housing, health, etc.) of the probationer during the initial intake process. The focus is then to direct the individual to the available resources (short-term and long-term) that will target those areas identified as critical in stabilizing the individual. This allows for the development of skills (e.g., education, skills training, employment, etc.) necessary to promote a healthier and more productive lifestyle. This process targets the needs of the probationer, as well as the family unit as a whole. Through the use of a strengths-based needs assessment, potential areas of need are identified. Targeted case management then provides referral (individual and family) to service providers within the community to assist the probationer. Cases are monitored throughout the term of the probation and case plans are modified to address the changing needs of the individual. The intended outcome is for the individual to have successfully addressed basic needs while on probation, thereby avoiding any unresolved critical issues at the termination of	

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		probation. At the time the Probation Department determines that a probationer no longer represents a direct threat to the safety of the victim or the community, and other conditions of probation have been met, the Department makes a recommendation to the Court for early termination/reduction of probation term and/or termination/dismissal of probation. ➢ **Capacity:** Serving 20,475 probationers. ➢ **Barriers:** a. Exit interviews are not conducted at the end of probation, as provisions for housing are not ordered by the courts. However, access to housing services are made available through referrals as indicated during probation supervision. Only the conditions of probation are addressed in making a determination for a recommendation to terminate an order of probation. Probationers, however, are required to file current address information on a regular basis throughout their term of probation. b. Although the Probation Department has access to available housing resources (i.e., GR for housing vouchers) and community-based organizations (the Salvation Army's substance abuse recovery homes for temporary or short-term housing, for example), greater interagency collaboration is needed.	